South Pacific Anesthesia
The Safe Anesthesia Specialists

# ADULT HEALTH HISTORY FOR DR. GEORGE ISTAPHANOUS

Patient's Name: _____ Sex: ____ DOB:_____

Address: _____

City: _____ Zip: _____ Height: _____ Weight: _____

Phone #: _____ Email:_____

Name of Primary Doctor/Phone:_____

**CIRCLE YES or NO as to the presence of history of the following conditions:**

| | | | | | |
|---|---|---|---|---|---|
| Recent Cold | NO | YES | Sleep Apnea | NO | YES |
| Asthma | NO | YES | Hypertension | NO | YES |
| Emphysema | NO | YES | Heart Attack | NO | YES |
| Diabetes | NO | YES | Irregular Heart Beat | NO | YES |
| Pregnant? | NO | YES | Chest Pain | NO | YES |
| Peptic Ulcer/Reflux | NO | YES | Back Trouble | NO | YES |
| Abnormal Bleeding | NO | YES | Stroke | NO | YES |
| Dentures | NO | YES | Alcohol/Drug Abuse | NO | YES |
| Tobacco Use | NO | YES | Regular Exercise? | NO | YES |

Broken Bones NO YES/Location? _____

Personal or Family History of Anesthesia Problems?

_____

When was your last electrocardiogram (EKG) done?

_____

Have you ever been told you have an **ABNORMAL EKG?** YES/NO Please explain:

_____

Any other medical problems_____

Allergies:_____

Current Medications:_____

_____

Prior Surgeries (Give Approx. Dates):_____

_____

Signature_____ Date: _____

Circle One: Patient/Parent/Guardian

[For Dr. Istaphanous only: Reviewed _____ Date: _____